STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155152	A. BUILDING 00 B. WING	12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO ASSISTED LIVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN47960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: December 12, 13, 14, 15, 2011 Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440 Survey Team: Linda Campbell, RN, TC Janet Stanton, RN Rita Mullen, RN Heather Lay, RN Michelle Hosteter, RN (December 12, 13, 14, 2011) Census Bed Type: SNF/NF: 88 Residential: 6 Total: 94 Census Payor Type: Medicare: 6 Medicaid: 64 Other: 24 Total: 94 Sample: 17 Supplemental Sample: 5 Residential sample: 6	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after January 14, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 12/19/11 Cathy Emswiller RN			
F0151 SS=D	The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. Based on interview and record review, the facility failed to allow a resident to choose a bedtime thus requiring the resident to go to bed at a facility chosen time. The deficient practice impacted 1 of 6 supplemental residents in a supplemental sample of 6. [Resident #28] Findings include: A Group meeting was held on 12/13/11 at 1:30 P.M. During interview at that time, Resident #28 indicated she had concerns with being made to go to bed at a facility chosen time each night. On 12/14/11 at 9:35 A.M., Resident #28's clinical record was reviewed. Diagnoses	F0151	**F 151 Right to Exercise Rights - free of reprisal** It is the practice of this provider to ensure that every resident has the right to choose their bedtime. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #28 is allowed to choose her bedtime. **How will you identify other**	01/14/2012

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	included but were not limited to, left hemiplegia, glaucoma, and history of seizure activity after stroke. A Minimum Data Set assessment dated 11/30/11 indicated a Brief Interview Mental Status [BIMS] score 15 of 15 [cognitively intact]. Functional status indicated transfers 3 of 3 [extensive assist of two]. In an interview on 12/14/11 at 9:50 A.M., Resident #28 indicated for the past 4 to 6 weeks, she had been put to bed before 9:00 P.M. and she did not agree or choose that time. She indicated the practice of scheduled bedtime was related to low facility census. She indicated the facility required a Certified Nursing Assistant [CNA] to go home by 9:05 P.M. The resident indicated she brought this matter up to the evening charge nurse 4 to 6 weeks ago and was instructed since she [Resident #28] was an assist of 2, she would be put to bed before 9:00 P.M. related to facility policy. She indicated she stayed in her electric wheelchair until bedtime and required gait belt transfer with assistance of two staff at all times. During interview on 12/14/2011 at 10:20 A.M., Licensed Practical Nurse [LPN] #2 indicated the facility did not have a policy related to low census and putting residents		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents that are able to choose their bedtime could be affected by the alleged deficient practice. · Interviewable residents will be interviewed to ensure they are being allowed to choose their bedtime. · For those residents unable to choose their bedtimes, family members will be interviewed in order to honor bedtime preferences. · All residents are allowed to choose the time they go to bed. · Staff were re-educated about allowing residents to choose their bedtime on December 20, 2011, by the Staff Development Coordinator. · A Post test was administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff were re-educated on December 20, 2011 to ensure every resident is given the right to choose their bedtime by the Staff Development Coordinator.	

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	to bed at a scheduled time. On 12/14/11 at 10:25 A.M., the Director of Nursing [DoN] indicated the facility did not have a policy related to low census and putting residents to bed at a scheduled time. 3.1-3(a)(1)		· A Post Test was administered. · Residents will be interviewed routinely to ensure they are allowed to choose their bedtime. Plans of care for all residents will be reviewed and updated quarterly and as needed for bedtime preferences by the interdisciplinary team. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool titled 'Accomodation of Needs' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · The Director of Nursing Services or her designee is responsible to monitor for	

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			compliance. **Compliance Date: January 14, 2012**	
F0246 SS=D	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on interview and clinical record review, the facility failed to ensure a resident's accommodation of preference was provided related to requested bedtime for 1 of 6 residents in a supplemental sample of 6. (Resident #28). Findings include: Group meeting was initiated on 12/13/11 at 1:30 P.M. At that time, Resident #28 indicated she had concerns with being made to go to bed at a facility chosen time each night. On 12/14/11 at 9:35 A.M., Resident #28's clinical record was reviewed. Diagnoses included but were not limited to, left hemiplegia, glaucoma, and history of seizure activity after stroke. A Minimum Data Set assessment dated 11/30/11 indicated a Brief Interview	F0246	**F 246 Reasonable Accommodation of Needs/Preferences** It is the practice of this provider to ensure that every resident has the right to choose their bedtime. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #28 is allowed to choose her bedtime. **How will you identify other residents having the potential**	01/14/2012

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	Mental Status [BIMS] score 15 of 15 [cognitively intact]. Functional status indicated transfers 3 of 3 [extensive assist of two]. In an interview on 12/14/11 at 9:50 A.M., Resident #28 indicated for the past 4 to 6 weeks, she had been put to bed before 9:00 P.M. and she did not agree or choose that time. She indicated the practice of scheduled bedtime was related to low facility census. She indicated the facility required a Certified Nursing Assistant [CNA] to go home by 9:05 P.M. The resident indicated she brought this matter up to the evening charge nurse 4 to 6 weeks ago and was instructed since she [Resident #28] was an assist of 2, she would be put to bed before 9:00 P.M. related to facility policy. Resident #28 was alert and oriented to person, place, and time. She indicated she stayed in her electric wheelchair until bedtime and required gait belt transfer with assistance of two staff at all times. On 12/14/2011 at 10:20 A.M., Licensed Practical Nurse [LPN] #2 indicated the facility did not have a policy related to low census and putting residents to bed at a scheduled time. On 12/14/11 at 10:25 A.M., the Director of Nursing [DoN] indicated the facility		**to be affected by the same deficient practice and what corrective action will be taken?** · Residents that are able to choose their bedtime could be affected by the alleged deficient practice. · Interviewable residents will be interviewed to ensure they are being allowed to choose their bedtime. · For those residents unable to choose their bedtimes, family members will be interviewed in order to honor bedtime preferences. · All residents are allowed to choose the time they go to bed. · Staff were re-educated about allowing residents to choose their bedtime on December 20, 2011 by the Staff Development Coordinator. · A Post Test was administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff were re-educated on December 20, 2011 to ensure every resident is given the right to choose their bedtime by the Staff	

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	did not have a policy related to low census and putting residents to bed at a scheduled time. 3.1-3(v)(1)		Development Coordinator. · A Post Test was administered. · Residents will be interviewed routinely to ensure they are allowed to choose their bedtime. Plans of care for all residents will be reviewed and updated quarterly and as needed for bedtime preferences by the interdisciplinary team. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool titled 'Accomodation of Needs' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · The Director of Nursing Services or her designee is	

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			responsible to monitor for compliance. **Compliance Date: January 14, 2012**	
F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the M.D.S. [Minimum Data Set] assessment accurately reflected the skin condition for 1 of 2 residents reviewed who had	F0278	**F278 Assessment Accuracy/Coordination/Certified** It is the practice of this provider to	01/14/2012

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	pressure sores; in a sample of 17 residents reviewed. [Resident #64] Findings include: In an interview during the initial orientation tour on 12/12/11 at 10:15 A.M., L.P.N. #7 indicated Resident #64 had an open area on the right buttock area, which she acquired in the facility. The clinical record for Resident #64 was reviewed on 12/12/11 at 12:45 P.M. Diagnoses included, but were not limited to, Down's syndrome, senile dementia--Alzheimer's type, hypothyroidism, insulin-dependent diabetes, and epilepsy. On 9/7/11, the physician ordered "Duoderm [a treatment/dressing for pressure sores] to open area right coccyx, left and right buttock." A Significant Change M.D.S. assessment, with an end-of-assessment period reference date of 9/18/11, indicated the resident had no pressure sores. In an interview on 12/15/11 at 11:05 A.M., the M.D.S. Coordinator indicated an error related to pressure ulcers was made on that M.D.S., and she had just submitted a corrected assessment to accurately reflect the pressure sores.		ensure that each Minimum Data Set assessment accurately reflects the skin condition of residents who have pressure sores. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The Minimum Data Set for Resident # 64 was corrected on December 15, 2011 while the surveyors were still in the building. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have pressure sores have the potential to be affected by the alleged deficient practice. · The MDS Coordinator has reviewed all Minimum Data Sets for residents with pressure ulcers to ensure accuracy. · The Minimum Data Set for residents with pressure sores will accurately reflect their skin condition. · The Interdisciplinary team will be	

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	3.1-31(i)		re-educated on Minimum Data Set accuracy by the RAI specialist or her designee by January 14, 2012. · A Post Test will be administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Interdisciplinary team will be re-educated on Minimum Data Set accuracy by the RAI specialist by January 14, 2012. · A Post Test will be administered. · The MDS coordinator will review each Minimum Data Set quarterly and as needed for residents with pressure sores to ensure their accuracy. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			· The CQI tool titled 'RAI Process'will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Director of Nursing Services or her designee is responsible to monitor for compliance. **Compliance Date: January 14, 2012.**	

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and interview, the facility failed to ensure that the Plan of Care reflected the care and services developed in coordination with a Hospice service, and identified each entity's responsibilities and respective functions; for 1 of 1 resident reviewed who was receiving Hospice services. [Resident #64] Findings include: In an interview during the initial orientation tour on 12/12/11 at 10:15 .A.M.., L.P.N. #7 indicated Resident #64 was receiving Hospice services. The resident was observed at that time laying in bed, which had a specialty low-air-loss	F0280	**F280 Right to Participate Planning Care - Revise CP** It is the practice of this provider to ensure that the Plan of Care for each resident with Hospice Service reflects the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Plan of Care for Resident #64 has	01/14/2012

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	mattress. The L.P.N. indicated the inflation level for the bed was written in the physician's orders. The clinical record for Resident #64 was reviewed on 12/12/11 at 12:45 P.M. Diagnoses included, but were not limited to, Down's syndrome, senile dementia--Alzheimer's type, hypothyroidism, epilepsy, insulin-dependent diabetes, and history of pathological fractures. Although the resident had physician orders for Tylenol and Morphine Sulfate pain medications on a P.R.N. [as needed] basis, Nursing progress notes indicated the resident was not experiencing any pain and none of the medications had been administered for pain in October, November, or December, 2011. A Hospice admission form, dated 9/8/11, indicated the resident was admitted to the Hospice service on 9/8/11. A facility Care Plan entry dated 9/21/11 addressed a problem of "Resident has impaired skin integrity: left/right buttock, right/left coccyx open lesion." There were 16 approaches/interventions listed, with 12 indicating [facility] "Nursing" discipline was responsible. The other approaches/interventions listed were as follows:		been reviewed with the Hospice Service to ensure that it reflects the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have Hospice Services have the potential to be affected by the alleged deficient practice. · The Plan of Care for residents with Hospice Service have been reviewed to ensure they reflect the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions. · The Interdisciplinary team will be re-educated to ensure that residents with Hospice Services have a Plan of Care that reflects the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions by the RAI specialist or her designeeby January 14, 2012. · A Post Test will be administered.	

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	"Hi low bed;" with "HP" and "Nursing" disciplines responsible. "Hospice consult;" "HP and "Nursing" disciplines responsible. "Low air loss bed setting at 3;" "HP and "Nursing" disciplines responsible. "Specialty cushion in chair;" "HP" and "Nursing" disciplines responsible. In an interview on 12/15/11 at 10:20 A.M., the Director of Nursing indicated the "HP" on the Care Plan meant "Hospice." There was no additional information indicating what care and services were to be included in each of these approaches, or the respective function, responsibilities, or extent of care for each discipline. A facility Care Plan entry dated 9/16/11 addressed a problem of "Resident is receiving hospice services related to diagnosis of failure to thrive, end stage Alzheimer's, dementia, Down's syndrome." Approaches were listed as follows: "Encourage socialization/activities as tolerated or able;" with Activity, Nursing, and Social Service disciplines to provide. "Hospice services per hospice plan of		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Interdisciplinary team will be re-educated to ensure that residents with Hospice Services have a Plan of Care that reflects the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions by the RAI specialist or her designee by January 14, 2012. · A Post Test will be administered. · The Interdisciplinary Team will review each Plan of Care for residents with Hospice Services to ensure they reflect the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions. · The MDS Coordinator will notify Hospice Services of the time and date of each Plan of Care review for residents with Hospice Services to ensure they reflect the care and services developed in coordination with the Hospice Service and identifies each entity's responsibilities and respective functions. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.	

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	care;" with [facility] Nursing discipline responsible. [A Hospice Care Plan was not found]. "Notify M.D. and hospice of unrelieved pain;" with Licensed Nurse responsible. "Observe for symptoms of pain; both verbal and non-verbal;" with Licensed Nurse, Nursing, and Hospice disciplines responsible. There was no additional information to demonstrate the division of responsibilities, or indicate the extent and frequency each discipline was to perform the service. "Provide a soothing environment for family/friend visits with resident;" with "All" disciplines responsible. "Provide interventions (med or non-pharmacological) for pain symptoms. Document effectiveness or P.R.N. meds;" with Licensed Nurse, Nursing, and Hospice disciplines responsible. There was no additional information to demonstrate the division of responsibilities, or indicate the extent and frequency each discipline was to perform the service. "Turn and reposition every 2 hours;" with Nursing and Hospice disciplines responsible. The facility Care Plan had an additional 18 entries, addressing problem issues which included, but were not limited to, broken/caries teeth, risk for falling-		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool titled: 'Hospice Services' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Director of Nursing Services or her designee is responsible to monitor for compliance. **Compliance Date: January 14, 2012.**	

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	-history of actual fall, bladder incontinence, seizure disorder, diagnosis of diabetes, risk for constipation, risk for pain due to history of fractured foot, dependent on staff for dressing and grooming, and weight loss. None of the 18 entries had approaches or interventions to be provided by the Hospice agency. In an interview on 12/15/11 at 10:20 A.M., the Director of Nursing indicated the Hospice agency did not come to every Care Plan conference, but did talk with staff every visit. She indicated the Hospice Plan of Care should be in a separate binder. At the final exit on 12/15/11 at 11:30 A.M., a Hospice Care Plan was not provided for review. 3.1-35(c)(2)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review, interview and	F0314	**F314 Treatments/SVCs to**	01/14/2012

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	observation, the facility failed to be proactive in the prevention of reoccurring pressure ulcers, for a Resident with a history of pressure ulcers, by developing nursing measures for the prevention of reoccurring pressure ulcers. This impacted 1 of 1 residents in a sample of 17. (Resident #20) Findings include: During the initial tour with LPN #2, on 12/12/11 at 10:10 A.M., she indicated Resident #20 had an acquired pressure ulcer on the right buttocks. The clinical record of Resident #20 was reviewed on 12/12/11 at 1:10 P.M. Diagnoses for Resident #20 included, but were not limited to, cerebral palsy, diabetes, seizures and dysphagia. Resident had a gastric feeding tube. A quarterly Minimum Data Set Assessment, dated 10/26/11, indicated Resident #20 had severely impaired decision making skills and no pressure ulcers. A Pressure Wound Risk Assessment, dated 10/26/11, indicated Resident #20 had impaired mobility, slid down in bed or chair, was incontinent of bowel and		**Prevent/Heal Pressure Sores** **It is the practice of this provider to ensure that the facility is proactive in the prevention of reoccurring pressure ulcers, for a resident who has a history of pressures ulcers, by developing nursing measures for the prevention of reoccurring pressure ulcers.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Nursing measures are in place for the prevention of reoccurring pressure ulcers for Resident # 20, who has a history of pressure ulcers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have a history of pressure ulcers have the potential to be affected by the alleged deficient practice.	

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	bladder and had a history of pressure ulcers. The Resident was at risk for developing skin breakdown. An Interdisciplinary Team note, dated 8/11/11, indicated a wound to the right buttocks, 1 cm (centimeter) X 1.5 cm X < 0.1 cm A nursing note, dated 8/26/11 at 11:30 P.M., indicated "Wound note: Area on right buttock resolved. Cont. (continue) to monitor X 1 more week...." A Nursing note, dated 9/18/11 at 10:15 A.M., indicated "Wound note: Resident noted to have re-opened area on [right] buttock. Measures 2 cm X 2 cm. Surrounding tissue [without] redness....Turn and reposition Q (every) 2 hrs (hours) [with] good body alignment maintained [with] pillows...composure mattress on bed for pressure reduction, speciality cushion in w/c (wheelchair)..." A review of the Pressure Wound Skin Evaluation Report, dated 9/18/11, indicated a stage II pressure ulcer to the right buttocks, 2 cm X 2 cm X <0.2 cm. The area was resolved on 10/18/11. A review of the Pressure Wound Skin Evaluation Report, dated 11/2/11, indicated a stage II pressure ulcer to the		· A skin assessment will be completed for current residents by the Nurse Management team by January 14, 2012. · The Physician will be notified and plan of care will be updated as needed. · The medical records for residents who have a history of pressure sores will be audited to ensure nursing measures are in place for the prevention of reoccurring pressure ulcers. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Re-education for nurses will be given by January 14, 2012 on Pressure Ulcer Prevention and Documentation by the Assistant Director of Nursing or her designee. · A Post Test will be administered. · Facility utilizes mattresses that are pressure-reducing/relieving which are in place for all beds, unless the Plan of Care indicates otherwise. · A skin assessment will be completed for current residents by the Nurse Management team	

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	right buttocks, 2.5 cm X 1 cm X < 0.2 cm. The following measurements were done on the following dates: 11/8/11: 3 cm X 0.8 cm X < 0.1 cm 11/15/11: 2 cm X 1 cm X < 0.1 cm 11/19/11: 2 cm X 1 cm X 0.1 cm 11/30/11: 0.3 cm X 0.2 cm X 0.1 cm 12/7/11: 3 cm X 1 cm X 0.2 cm. The physician was called and the treatment was changed to duoderm. During an observation with the Assistant Director of Nursing Services (ADoN), on 12/14/11 at 2:10 P.M., the pressure area measured 3 cm X 1 cm X < 0.1 cm. The area was dark pink in color with lighter pink skin surrounding the area. There was no drainage or odor. A Care Plan, dated 10/4/11, for "... Moderate to high risk for skin breakdown. Has recurring open areas to buttocks." Approaches for nursing included: Composure mattress (6/15/11), check and change Q 2 hours. Provide incontinent care after each incontinent episode, and turn and reposition routinely (1/5/11), Meds and treatments per MD order		by January 14, 2012. · The Physician will be notified and plan of care will be updated as needed. · The medical records for residents who have a history of pressure sores will be audited to ensure nursing measures are in place for the prevention of reoccurring pressure ulcers. · The Charge Nurse will ensure that nursing measures are in place each shift for residents who have a history of reoccurring pressure ulcers per the care plan by conducting rounds. · Residents' wound risk assessments are reviewed by the Interdisciplinary team no less than quarterly and as needed to ensure preventative measures are in place to prevent pressure ulcers and/or treatments to promote healing. · The licensed nurse completes skin assessments on all residents weekly. · The physician is notified for treatment and the plan of care and the aide assignment sheets are updated as needed. · The Interdisciplinary team completes weekly wound rounds for residents with pressure sores to ensure preventative measures are in place and to monitor effectiveness of treatment. · The Unit Manager is responsible to ensure the skin assessments are completed and the treatments have	

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	(1/5/11), notify MD as needed (1/5/11), skin precautions, cushion in wheelchair, elevate heels with pillows (1/5/11), treatment per MD orders (1/5/11) and weekly skin assessments on shower day (1/5/11). No new nursing interventions were put in place to prevent the recurring Stage II pressure ulcers since 6/15/11. A Care Plan, dated 12/4/11, for "Resident has impaired skin integrity: Stage II. Location: right buttock." Approaches for nursing included: Treatment as ordered-peleverus clear ointment to bilateral buttock after each incontinent episode and at night for protection (10/27/11), Treatment as ordered-granulex spray three X a day and as needed (11/19/11), assess for pain (11/2/11), assess wound weekly (11/2/11), notify MD of worsening or no change in wound or sign of infection (11/2/11), pressure reducing/redistribution mattress on bed-composure mattress (6/14/11), tube fed-optimental (3/18/11), incontinent care ads needed (10/23/09), pressure reducing/redistribution cushion in chair (10/23/09) and turn and reposition every 2 hours (10/23/09). No new nursing intervention were put in place to prevent recurring Stage II pressure ulcers since 11/19/11. A "Skin Management Program," dated		been completed and documented as ordered. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool titled 'Pressure wounds-treatment audit' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance with assessment and documentation procedures. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Director of Nursing Services or her designee is responsible to monitor for compliance.	

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	3/2010, received from the Director of Nursing Services, on 12/15/11 at 11:25 A.M., indicated "It is the policy of American Senior Communities to assess each resident to determine the risk of potential skin integrity impairment, upon admission, quarterly, annually, and with significant change. Residents will have a skin assessment completed no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment....A care plan will be developed specific to the resident's needs including prevention interventions....The care plan will be initiated/revised addressing any new areas...." During an interview with the ADoN, on 12/14/11 at 1:30 P.M., she indicated Resident #20 has a lot of scar tissue on the buttock from old pressure ulcers. They had gotten the wheelchair cushion changed, were using a body pillow for positioning in bed and a composite mattress to reduce pressure. An Occupational Therapy note, dated 1/31/11, indicated "New gel seat cushion arrived. Removed the old J-2 seat cushion and replaced with the new T-foam cushion with checked gel layer on top, and with coccyx cut out...."		**Compliance Date: January 14, 2012**	

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	A physician's order, dated 6/14/11, indicated "Composure mattress." A physician's order, dated 8/4/11, indicated "May use Body Pillow for positioning." 3.1-40(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure interventions were in place to prevent falls related to a motion sensor and staff supervision for 1 of 4 residents with falls in a sample of 17. (Resident # 76).	F0323	**F323 Accidents and Supervision** It is the practice of this provider to ensure interventions are in place to prevent falls related to a motion	01/14/2012

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	Findings include: On 12/12/11 at 9:45 A.M., during an initial tour with LPN #1, Resident # 76 was identified as having a history of falls, having alarms, and requiring assistance to ambulate, and had a prosthesis on the left leg. The resident's last fall had occurred when she attempted to ambulate by herself from the bathroom. On 12/13/11 at 10:00 A.M., with LPN #1, Resident # 76 was observed lying in her bed in her room. The motion sensor was on top of the dresser behind the door and was turned off. Interview with LPN # 1 indicated the motion sensor should have been by the bed and turned on. Resident # 76's clinical record was reviewed on 12/12/11 at 10:45 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus, congestive heart failure, peripheral neuropathy, left below the knee amputation, mild dementia, memory problems, and generalized weakness. A Minimum Data Set (MDS) Quarterly Assessment dated 11/24/11 indicated the resident was cognitively intact, required extensive one-person physical assistance		sensor and staff supervision. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #76 has a motion sensor that is in place and activated when in bed. · The motion sensor is on the Plan of Care and the Aide Assignment Sheet for Resident #76. · It is documented on the Plan of Care and the Aide Assignment Sheet that Resident # 76 should not be left alone while using the bathroom. · Staff will be re-educated about the use of the motion sensor while in bed to alert staff of unassisted transfers for Resident #76 by January 14, 2012, by the Staff Development Coordinator or her designee. · Staff will be re-educated about the need to not leave Resident #76 unattended while using the bathroom by January 14, 2012, by the Staff Development Coordinator or her designee.	

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	for transfer, ambulation, and toilet use, was unsteady during transitions and walking, had functional impairment of both lower extremities, and had no falls. A fall risk assessment dated 8/30/11 indicated the resident "...has diagnosis of and/or demonstrates evidence of impaired gait/balance" and "...is confused and/or disoriented..." The assessment indicated the resident was at risk for experiencing falls. A resident care plan dated 12/20/11 indicated "...Resident is at risk for falls and has had an actual fall...10/18/11... Pressure alarm to chair, 9/19/11...Motion sensor at bedside. Check placement and functioning q (every) shift and PRN (as needed)..." A resident care plan dated 9/8/11 indicated "...Moderate impaired cognition. Recall poor. Increased periods of confusion..." A physician orders recapitulation dated December 2011 indicated "...9/19/11 Motion alarm at bedside to alert staff of attempts to get out of bed unassisted. Check placement and function alarm every shift..." and "10/18/11 Pressure alarm when up in wheelchair to alert staff of attempts to get unassisted (sic). Check		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have alarms in place to alert staff of unassisted transfers have the potential to be affected by the alleged deficient practice. · The Plans of Care and the Aide Assignment sheets of residents with alarms in place to alert staff of unassisted transfers were reviewed on December 14, 2011 while the surveyors were still in the building and updated as needed to reflect the need to stay with residents whenever alarms are turned off to provide care. · The Plans of Care and the Aide Assignment sheets of residents with alarms in place to alert staff of unassisted transfers were reviewed on December 14, 2011 while the surveyors were in the building and updated as needed to reflect the need for the alarm. · Staff will be re-educated on the purpose of alarms and the need to stay with residents whenever alarms are turned off to provide care by January 14, 2021 by the Staff Development Coordinator or her designee. · A Post Test will be administered. **What measures will be put into**	

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	placement and function every shift..." A nurses' note dated 11/9/11 at 4:55 A.M. indicated "Res (resident) was getting her clothes from closet & went to turn around to walk to bed & lost balance falling backwards hitting middle of back on foot board of bed. Bruise red-purplish forming 6 cm (centimeters) - 3 cm left of spine...Writer outside room & 0 (no) witness fall, assisted Res to bed..." A "Post Fall Investigation" dated 11/9/11 indicated "...The unit charge nurse was assisting her and then stepped to the med (medication) cart to obtain something for (resident #76 name). (Resident #76 name) then attempted to turn by herself, lost her balance and fell..." An "Employee Communication Form" dated 11/10/11 indicated "...Residents that are fall risk & have interventions are not to be left unattended..." A resident care plan dated 12/20/11 indicated documentation was lacking related to not leaving the resident unattended while standing. A "Resident Progress Note" dated 12/6/11 at 1:15 P.M. indicated "Res. was attempting to take self back to W/C (wheelchair) from bathroom. Did not use		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff will be re-educated on the purpose of alarms and the need to stay with residents whenever alarms are turned off to provide care by January 14, 2012 by the Staff Development Coordinator or her designee. · A Post Test will be administered. · Aide Assignment sheets are updated daily, excluding weekends and holidays, to reflect changes in the residents' needs. · Change of condition is passed on at change of shift on the weekends and holidays. · Each resident's Plan of Care is reviewed and updated quarterly and as needed to reflect the residents' needs. · The Charge Nurse will ensure that nursing measures are in place each shift for residents who have alarms per the care plan by conducting rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool 'Fall Management' will be utilized by	

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	call light to notify staff that she was finished. Upon entering room, found res lying on back on the floor. No injuries noted..." A "Post Fall Investigation" dated 12/6/11 indicated "...Staff had stepped away from the bathroom and she tried to transfer herself. She fell during the attempted transfer..." An "Employee Communication Form" dated 12/7/11 indicated "...When someone has an alarm in chair DT (due to) fall risk, they must not be left unattended in B/R (bathroom)..." An "Event Report" dated 12/6/11 indicated "...Was fall witnessed...No...What intervention(s) was put into place to prevent another fall...Encouraged res. to use call light..." A resident care plan dated 12/20/11 indicated documentation was lacking related to not leaving the resident unattended in the bathroom. Interview on 12/13/11 at 10:10 A.M. with LPN #1 indicated the resident was cognitively impaired and "stubborn." She indicated on 11/9/11 the nurse left the resident alone to go to a cart outside the room and the resident fell. LPN #1		the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Director of Nursing or her designee is responsible to monitor for compliance. **Compliance Date: January 14, 2012**	

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	155152	A. BUILDING 00 B. WING	12/15/2011

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	indicated the resident should not have been left alone in the room. LPN #1 indicated on 12/6/11 a CNA left the resident alone in the bathroom and the resident "should not have been left alone." Review on 12/14/11 at 8:25 A.M. of a facility policy and procedure dated 7/01, revised on 7/04, 9/06, and 3/10, provided by the Executive Director, identified as current, and titled "Fall Management Program" indicated "...Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift...The care plan will be reviewed and updated, as necessary..." 3.1-45(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on a review and interview, the facility failed to ensure non-pharmaceutical interventions were attempted prior to administration of as needed Lorazepam (antianxiety medication) for 1 of 4 residents on antianxiety medications in a sample of 17. (Resident #63). Findings include: Resident #63's clinical record was reviewed on 12/13/11 at 12:53 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, altered mental status and	F0329	**F329 Drug Regimen is Free from Unnecessary Drugs** It is the practice of this provider to ensure that non-pharmaceutical interventions are attempted and documented prior to administration of an antianxiety medication. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	01/14/2012

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	anxiety. A physician's orders recapitulation dated December 2011 indicated Lorezapam 0.5 mg (milligrams) tab (tablet). Take 1 tablet per G-Tube (gastrostomy tube) 3 times daily needed for mild - moderate agitation..." Medication Administration Records indicated: November 2011 - the lorazepam had been administered on 11/4/11, 11/21/11, 11/22/11 (twice), 11/26/11, and 11/29/11 without documented interventions prior to administration. Review of behavior monitoring sheets and nurses' notes indicated documentation was lacking related to non-pharmaceutical interventions being attempted prior to the administration of the lorazepam. December 2011 - the lorazepam had been administered on 12/7/11, 12/9/11, 12/10/11, 12/11/11, and 12/12/11 without documented interventions prior to administration. Review of behavior monitoring sheets dated November 1 through December 13, 2011 and nurses' notes dated November 1 through December 13, 2011 indicated documentation was lacking related to non-pharmaceutical interventions being		· Resident #63's antianxiety medication is being administered per physician's order. · Non-pharmacological interventions are attempted and documented prior to administration of prn antianxiety medication for resident #63. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents with a physician's order related to prn antianxiety medication use have the potential to be affected by the alleged deficient practice. · The medical records for those residents receiving a prn antianxiety medication were reviewed and updated as needed on December 13, 2011 while the surveyors were still in the building. · Nursing staff were re-educated on December 13, 2011 about the need to attempt and document non-pharmacological interventions before administering prn antianxiety medication by the Nurse Management team. · Nursing Staff will be re-educated on the need to attempt and document non-pharmacological interventions	

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	attempted prior to the administration of the lorazepam. Interview on 12/13/11 at 1:45 P.M. with the Social Services Director indicated interventions were documented on behavior monitoring sheets and interventions should have been attempted prior to the administration of the lorazepam. A policy and procedure was requested from the Social Services Director on 12/13/11 but was not provided for review by the exit date of 12/15/11. 3.1-48(a)(4)		before administering prn antianxiety medication by January 14, 2012 by the Staff Development Coordinator or his designee. · A Post Test will be administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nursing Staff will be re-educated on the need to attempt and document non-pharmacological interventions before administering antianxiety medication by January 14, 2012 by the Staff Development Coordinator or his designee. · A Post Test will be administered. · Behavior monitoring records will be reviewed on a daily basis, excluding weekends and holidays, by the Interdisplinary team to ensure that non-pharmacological interventions are attempted and documented before the administration of prn anitianxiety medication. · The Medication Administration Record will be reviewed on a daily basis, excluding weekends and holidays, by the Unit Manager or their designee to ensure that non-pharmacological interventions are attempted and documented before the administration of prn anitianxiety medication.	

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			· Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool 'Unnecessary Medications ' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Director of Nursing Services or her designee is responsible to monitor for compliance. **Compliance Date: January 14,**	

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F0465 SS=B	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure that all equipment in resident areas were safe and functional for 4 of 5 units in the facility. (BCD unit, 2 West unit, Cottage 1 unit, and Cottage 2 unit). Findings include: The environmental tour was completed with the Maintenance Supervisor and the Housekeeping and Laundry Supervisor on 12/14/11 at 10 A.M. At 10:15 A.M., the BCD shower room was found to have a hoyer lift in it, the Maintenance Supervisor indicated at that time that those were not to be stored in the shower room but along wall in hallway. At 10: 25 A.M., the Cottage 1 shower room was found to have four half tiles that were missing in the middle in front of the shower where a resident is taken out of the shower. The Maintenance Supervisor indicated at that time that he can put some tiles in to replace the ones that are missing.	F0465	**2012** **F465 Safe/Function/Sanitary/Comfortable Environment** It is the practice of this provider ensure that all equipment in resident areas is safe and functional. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The hoyer lift has been removed from the shower room. · The tiles in the Cottage 1 shower were replaced on December 14, 2011 while the surveyors were still in the building. · The shower head in the 2 West shower room was repaired on December 14, 2011 while the surveyors were still in the building. · The call light in Room 247	01/14/2012

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	At 11:05 A.M., the 2 West unit the shower head near the base of the handle had part of the coil of the cord missing on it. The Maintenance Supervisor indicated that it needed fixed. At 11:10 A.M. when testing the call light on the Cottage 2 unit, Room 247's call light did not light up when pulled. The Maintenance Supervisor indicated at that time, the bulb must be burned out. 3.1-19(f)		was replaced on December 14, 2011 while the surveyors were still in the building. Even though the call light did not light up in the resident room, it did still sound at the nurse's station. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · The facility ensures that all equipment in resident areas is safe and functional. · Staff will be re-educated on the importance of notifying the Maintenance Supervisor or his designee with any concerns about resident equipment by the Maintenance Supervisor or his designee by January 14, 2012. · A Post Test will be administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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			· Staff will be re-educated on the importance of notifying the Maintenance Supervisor or his designee with any concerns about resident equipment by the Maintenance Supervisor or his designee by January 14, 2012. · A Post Test will be administered. · The Maintenance Supervisor or his designee will ensure implementation or compliance by conducting rounds routinely to ensure that all equipment in resident areas is safe and functional. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool 'Facility Environmental Review' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to	

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			ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Maintenance Supervisor or his designee is responsible to monitor for compliance. **Compliance Date: January 14, 2012**	
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to accurately document a resident's pulse when administering a medication with hold parameters for pulse less than 60 and failed to document fluid intakes for a resident on fluid restriction. The deficient practice impacted 2 of 17 residents reviewed. [Residents #56 and #86]	F0514	**F514 Clinical Records** It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	01/14/2012

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	Findings include: 1. On 12/12/11 at 9:45 A.M., tour of the facility was initiated with Licensed Practical Nurse [LPN] #1. Resident #86 was identified with a fall history, interviewable, and up without assistance. On 12/13/11 at 12:45 P.M., Resident #86's record was reviewed. Diagnoses included, but were not limited to, anxiety, depression, anemia, dementia with delusions, and psychotic behaviors. A Physician's Orders dated 12-01-2011 through 12-21-2011 included, but was not limited to, "Atenolol 50 milligrams by mouth twice daily... Hold for pulse less than 60... start date 6/12/09." A Medication Record dated 6-1-11 to 6-30-11, 8-1-11 to 8-31-11, 9-1-11 to 9-30-11 included, but was not limited to, "Atenolol 50 milligrams by mouth twice daily... Hold for pulse less than 60... start date 6/12/09." The pulse was not documented on 6/4/11, 6/22/11, 6/29/11, 8/8/11, 8/10/11, 8/11/11, or 10/10/11. 2. In an interview during the initial orientation tour on 12/12/11 at 10:15 A.M., L.P.N. #7 indicated Resident #56 was alert/oriented, interviewable, required hemodialysis three times a week, and was		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The facility maintains accurate and complete clinical records related to documentation of Resident #86's pulse when administering medication with hold parameters. ·The facility maintains accurate and complete clinical records related to fluid intakes for Resident #56. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with physician orders related to fluid intake and pulse parameters with medication administration have the potential to be affected by the alleged deficient practice. · Medical records of residents with physician orders related to fluid intake and pulse parameters with medication administration were reviewed and updated as needed to reflect the resident's needs.	

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	on a fluid restriction. The nurse indicated the resident was non-compliant with the fluid restriction. The clinical record for Resident #56 was reviewed on 12/13/11 at 1:15 P.M. Diagnoses included, but were not limited to, end-stage renal disease with hemodialysis, insulin-dependent diabetes, depression and anxiety, coronary artery disease with past by-pass surgery, obstructive sleep apnea, and gastroesophageal reflux disease. On 5/25/11, the physician ordered a 2000 cc. [cubic centimeter] per day [24 hours] fluid restriction. The Dietary Department was to provide "1220 cc. with meals each day--divided to provide 600 cc. with breakfast, 240 cc with lunch, and 480 cc. with supper." The Nursing Department was to provide "680 cc.--60 cc. for the night shift, 300 cc. for the evening shift, and 320 cc. for the day shift." On 11/28/11, the physician ordered the fluid restriction reduced to 1600 cc. per day. The Dietary Department was to provide 350 cc. a day, and the Nursing Department was to provide 1240 cc. per day. In an interview on 12/13/11 at 12:50 P.M., Resident #56 indicated he was		· Nurse staff will be re-educated regarding documentation related to fluid intake and pulse parameters with medication administration by the Staff Development Coordinator or her designee by January 14, 2012. · A Post Test will be administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurse staff will be re-educated regarding documentation related to fluid intake and pulse parameters with medication administration by the Staff Development Coordinator or her designee by January 14, 2012. · A Post Test will be administered. · The Unit Manager is responsible to ensure documentation related to fluid intake and pulse parameters with medication administration has been completed and documented as ordered, by performing routine audits of the medical records of those residents with fluid restrictions and pulse parameters. · The Staff Development Coordinator or her designee will ensure implementation or compliance by conducting routine skills validations.	

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	aware of his fluid restriction. He indicated he had no water pitcher in his room, and got a cup of ice on his meal trays. The resident indicated "the nurses" keep track of his fluid intakes. In an interview on 12/15/11 at 10:10 A.M., the Director of Nursing indicated the amount of fluids the resident consumed for the Nursing Department allowance would be documented on the M.A.R. [Medication Administration Record]. The amount of fluids consumed with meals would be documented on the "Food/Fluid Intake Record" forms. The October, 2011 M.A.R. listed the fluid restriction order from 5/25/11 as a "F.Y.I." ["For Your Information"]. The amounts consumed each shift were not documented. The October, 2011 "Food/Fluid Intake Record" had intake amounts documented as 240-360 cc. for breakfast, 240 cc. for lunch, and 240 cc. for supper. There were no totals for amount of fluids consumed for each 24 hour period. The November, 2011 M.A.R. listed the order from 5/25/11 as a "F.Y.I." Nothing was documented related to the amounts of fluids consumed until the order was		· Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tools titled 'Documentation Mar/Tar Flowsheets' and 'Fluid Restrictions' will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re- education and/or disciplinary action. **Compliance Date: January 14, 2012**	

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	changed on 11/28/11. On 11/28, 300 cc. was documented for the total on the evening shift; on 11/29, 240 cc. was documented for the day and evening shifts and 300 cc. for the night shift; and on 11/29, 240 cc. was documented for the day shift. The November, 2011 "Food/Fluid Intake Record" had intake amounts of 360-480 cc. for breakfast; 240-360 cc. for lunch, and 240-480 cc. for supper. There were no totals for the amount of fluids consumed for each 24 hour period. In the interview on 12/15/11 at 10:10 A.M., the Director of Nursing indicated the facility pharmacy provided the M.A.R.s, and was not sure why the order was listed with a "F.Y.I." designation. She indicated the December, 2011 M.A.R. also had the "F.Y.I." designation. 3.1-50(a)(1)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to do a written Resident Evaluation prior to admittance to the facility. This impacted 1 of 6 Residential charts reviewed in a sample of 6. (Resident R4) Residential findings include: The clinical record of Resident R4 was reviewed on 12/15/11 at 8:50 A.M. Resident was admitted on 10/3/11. Diagnoses included but were not limited to, high blood pressure, diabetes, and diabetic neuropathy. A Pre-Admission Evaluation was not found. An Admission Assessment was done on the day of admittance to the facility, 10/3/11. During an interview with the Executive Director, on 12/15/11 a 9:45 A.M., she indicated the Resident came in the week before he and his wife were admitted. The facility staff talked with him and	R0214	**R214 Evaluation** It is the practice of this provider that a written evaluation of the individual needs of each resident is initiated prior to admission. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · An evaluation of Resident R4 has been done since admission. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residential residents have the potential to be affected by the alleged deficient practice.	01/14/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155152	A. BUILDING 00 B. WING	12/15/2011

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	determined he was appropriate. There was nothing written down, no formal evaluation.		· All residential residents will receive a written evaluation prior to admission. · Nurse staff will be re-educated regarding documentation related to pre-admission evaluation by January 14, 2012 by the Staff Development Coordinator or her designee. · A Post Test will be administered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurse staff will be re-educated regarding documentation related to pre-admission evaluation by January 14, 2012 by the Staff Development Coordinator or her designee. · A Post Test will be administered. · All residential residents will receive a written evaluation prior to admission. · The Interdisciplinary Team will ensure implementation or compliance by reviewing the pre-admission evaluation prior to acceptance of admission. · Non-compliance with facility policy and procedure may result in	

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			employee re-education and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The tool "Evaluation Agreement for Residential Healthcare Services" will be utilized by the Interdisciplinary team prior to admission to the Residential Unit. · The Medical Records of new admissions will be reviewed by the Interdisciplinary Team within 24 hours after an admission, excluding weekends and holidays, to ensure the evaluation agreement has been completed. · The CQI committee reviews the audits monthly and action plans are developed if the threshold of 90% is not met to ensure continual compliance. · Non-compliance with facility policy and procedure may result in employee re- education and/or disciplinary action.	

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			Compliance Date: January 14, 2012.	